



## STUDENT HEALTH FORM

To be completed by Parent / Guardian

\_\_\_\_\_  
Student name (last / first / middle)                      Date of birth                      Grade

\_\_\_\_\_  
Home phone number                      Email address

\_\_\_\_\_  
Mother's name                      Mother's mobile number / work nr.

\_\_\_\_\_  
Father's name                      Father's mobile number / work nr.

Your child may be released to the following individual for minor illnesses or injury, if custodial parents cannot be reached (Relative, Neighbour or Friend).

\_\_\_\_\_  
Name                      Relationship                      Phone number

\_\_\_\_\_  
Family doctor's name                      Phone number

Hospital preferred: \_\_\_\_\_  
Phone number

Parental permission is given for student to receive treatment and medication for minor illnesses or injuries at school. Please indicate 'Yes' or 'No'     'YES'     'NO'     'YES', with these restrictions

Does your child have a health condition(s) which require **EMERGENCY ACTION** while he / she is in school (e.g. seizure, asthma, insect allergy, bleeding problems, diabetes, heart problem)? 'YES' \_\_\_\_\_ 'NO' \_\_\_\_\_

If 'YES', please describe

\_\_\_\_\_  
\_\_\_\_\_

**If your child has medication(s) for emergency action, please bring it to the School Nurse.**

## ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge, does your child have any problems that may affect his/her learning in school, cause concern and/or be important for school staff to know?  
Please indicate 'YES' or 'NO' for each of the following.

Area of concern	No	Yes	Comments
Allergies (drugs, food, insects) Bee- sting reactions specify	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Ear problem or deafness	<input type="checkbox"/>	<input type="checkbox"/>	
Eye or vision problems	<input type="checkbox"/>	<input type="checkbox"/>	
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	
Limits of activity	<input type="checkbox"/>	<input type="checkbox"/>	
Medication	<input type="checkbox"/>	<input type="checkbox"/>	
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>	
Problem with bladder	<input type="checkbox"/>	<input type="checkbox"/>	
Problem with bowels	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Speech problem	<input type="checkbox"/>	<input type="checkbox"/>	
Others	<input type="checkbox"/>	<input type="checkbox"/>	

### INFORMATION FOR SPORTS

Area of concern	No	Yes	Comments
Advised by physician to restrict activity	<input type="checkbox"/>	<input type="checkbox"/>	
Has been unconscious	<input type="checkbox"/>	<input type="checkbox"/>	
Has fainted	<input type="checkbox"/>	<input type="checkbox"/>	
Has had a convulsion(s)	<input type="checkbox"/>	<input type="checkbox"/>	
Unusually short of breath under light exercise	<input type="checkbox"/>	<input type="checkbox"/>	
Has had sports injuries	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	
Weak or ill when exposed to high temperatures	<input type="checkbox"/>	<input type="checkbox"/>	
Has had surgery or fracture(s)	<input type="checkbox"/>	<input type="checkbox"/>	
Limits of activities (sports)	<input type="checkbox"/>	<input type="checkbox"/>	
Others	<input type="checkbox"/>	<input type="checkbox"/>	

Is your child allowed to participate in all kinds of sports?  'YES'  'NO'

If 'NO', please describe \_\_\_\_\_

**Comments and / or concerns regarding health and / or sports activities:**

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Is your child taking any medication regularly at home:  'YES'  'NO'

If 'YES': Name : \_\_\_\_\_

Dosage: \_\_\_\_\_

Reason: \_\_\_\_\_

Your child's **Blood Type**: \_\_\_\_\_ (if known)

### IMMUNIZATION / INNOCULATION

It is **strongly recommended** by the school that your child has the following vaccinations.  
Please check for updates with a physician

Polio	_____	Measles	_____
Pertussis P	_____	Mumps M	_____
Diphtheria D	_____	Rubella R	_____
Tetanus T	_____	Meningococcal	_____
Hib (haemophilus influenza)	_____	BCG / TB	_____
Hepatitis A	_____	Anti-Rabies	_____
(after age of 10 years if no immunity)			
Hepatitis B	_____	Flu	_____
Yellowfever	_____		

Kindly indicate the last vaccination dates, so that in case of sickness we can give recommendations.

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### MALARIA PREVENTION

Before every school trip outside Nairobi, parents / guardians should take advice from a physician concerning malaria prevention.

Please take note that some parts of the student's file for practical reasons will be stored in a school computer.

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**Signature of Parent / Guardian**

## OPTIONAL INFORMATION

If you like to discuss your child's health with school personnel, please indicate title:

(School Nurse, Teacher, Counselor, Principal or Special area Staff)

Title \_\_\_\_\_

**BLOOD BANK – file** (optional – to be used only for students)

Father's name \_\_\_\_\_ Blood Type \_\_\_\_\_

Mother's name \_\_\_\_\_ Blood Type \_\_\_\_\_

People who have had malaria within the last five years, known history of cancer or hepatitis can not be blood donors.

Nurse's notes:

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